

Johnson (H. L. E.)

al

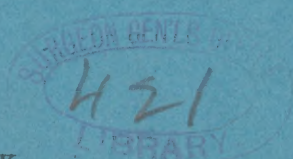
A CASE OF
ACCIDENTAL HEMORRHAGE
FROM THE
GRAVID UTERUS.

BY

H. L. E. JOHNSON, M.D.,

Professor of Gynecology in the Medical Department of the Columbian University :
Surgeon in Charge of the Department of Diseases of Women in
Central Dispensary and Emergency Hospital,
Washington, D. C.

[Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES
OF WOMEN AND CHILDREN, Vol. XXIII., No. 11, 1890.]



NEW YORK :
WILLIAM WOOD & COMPANY, PUBLISHERS,
56 & 58 LAFAYETTE PLACE.
1890.

A CASE OF ACCIDENTAL HEMORRHAGE

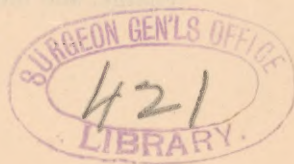
FROM THE
GRAVID UTERUS.¹

THE various gynecological subjects have been so frequently and thoroughly discussed during the past few years that little remains worthy of more than a passing comment.

Who would now venture to occupy the hour with the discussion of the lacerated perineum (which, by now, will not hold another stitch), or the cervix uteri, or the shrinking, hiding, unoffending normal ovary, or the much-offending tubes? All the paths and approaches to this scientific temple have been beaten down and hardened by the constant tramp of many feet of passing gynecological pilgrims and devotees, so that the novice is left no opportunity to leave his "footprints in the sands of time."

It is nigh impossible to present anything new or to speak better upon any of the old subjects. Nevertheless, at the risk of "threshing over old straw," I will venture to present, for the consideration of the Society, a case arising in my practice which has to commend its introduction its extreme rarity of occurrence, its even greater rarity in the result.

¹ Read before the Washington Obstetrical and Gynecological Society, February 7th, 1890.



As I have attended this patient in all her confinements, I will, if the Society will indulge me, refer to some facts connected with previous labors before proceeding to the presentation of the particular one made the subject of this paper.

The normal attachment of the placenta at the upper zone of the uterus and far away from the point which is occupied in placenta previa, of either variety, does not absolutely insure the patient against its partial separation with accompanying hemorrhage, which may be slight or severe, retained in utero or flow out between decidua vera and reflexa, and be of such character as to cause death of both child and mother. This variety is termed "accidental hemorrhage," and must not be confounded with that caused by the separation of a placenta situated at the lower zone of the uterus and known as unavoidable hemorrhage. Goodell mentions four conditions under which concealed hemorrhage takes place: (*a*) when the placenta is centrally detached and the blood accumulates in the cul-de-sac formed by the firm adhesion of its margin to the uterine wall; (*b*) when the placenta is so detached that the blood escapes into the uterine cavity behind the membranes near the fundus; (*c*) when the membranes are ruptured near the detached placenta, and the effused blood mingles with the liquor amnii; (*d*) when the presenting part of the fetus so accurately plugs up the natural outlet that no existing hemorrhage can escape externally.

The circumstances leading to placental detachment Goodell found to be irregular uterine contractions, external violence, and undue exertion. In seven the causes were purely emotional, and ten took place during sleep. It occurs more frequently in multiparæ and in the latter months of pregnancy.

As to its frequency, Boivin and La Chapelle have denied its occurrence. In 22,498 confinements at Guy's Hospital it occurred but 3 times, and in 156,100 confinements at the Rotunda in Dublin it was not observed at all. Goodell was able to collect but 106 cases.

The symptoms, as stated by Lusk, are an alarming state of collapse, pain, often excessive, absence or extreme feebleness of labor pains, marked distention of the uterus, sometimes a lateral bulging of the uterine walls, a show of blood, a serous discharge, and blood in the liquor amnii.

The diagnosis in the concealed form may be extremely embarrassing. The pain is often that of flatulent colic. The accident likewise presents many features which resemble those of ruptured uterus, but rupture, by contrast, rarely occurs until after the escape of the waters, the presenting part then receding from the os and the uterus diminishing in size.

The prognosis is very unfavorable. Goodell reports out of 106 tabulated cases 54 mothers perished, and out of 107 children 6 alone are known to have been saved. Lusk has had a case since in which he removed, after labor, at least a basinful of firm clots from the uterine cavity, and yet mother and child both lived. He says: "In my own case the Barnes dilator acted capitally, not only enabling me to expand the cervix, but excited the uterus to contract vigorously. The serious symptoms set in after the membranes were ruptured, and compelled me to deliver with forceps."

In the *Medical News* of November 30th, 1889, Dr. W. W. Jaggard reports three cases of external and internal hemorrhage, without rupture of the amnion, in which the mothers recovered, but all the children were still-born.

In cases of external hemorrhage the diagnosis is easy and the prognosis more favorable—the latter probably because the walls are less flaccid than in the concealed form.

Treatment.—Subcutaneous injections of ergotin, dilatation with Barnes' bags, in rupture of the membranes and in version.

CASE.

Mrs. F., æt. 33, white, always strong and healthy until after third confinement. First child, male, born November 29th, 1882. Labor normal, child healthy and still living.

Second child, female, born June 20th, 1884. Labor rapid, and lying-in normal till seventh day, when nurse used wrong nozzle of syringe and injected water into uterus. Violent uterine colic followed, but soon responded to treatment.

Third child, male, born August 7th, 1886. Labor normal, but followed by severe post-partum hemorrhage, from which she nearly lost her life. Child had trismus nascentium on the third day, and died on the fifth day. Mother recovered and gained strength, but became very nervous, and about one and

a half months post partum developed mania and at times was violent; had hallucinations about the house and members of her family; uterus normal, urine normal. She was sent to the country with friends; returned in excellent condition, with mind clear, and quite cheerful.

Fourth child, male, born December 10th, 1887. Had examined urine three months before and found it normal. After this, patient failed to send urine for examination. When next sent for I found her in labor and progressing nicely, but was struck by her peculiar pallor. Insisted upon having urine, and on examination found it contained over three-fourths, by volume, of albumin. I made all preparations for rapid delivery in case of convulsions. The labor progressed, however, without a bad symptom, lasted six hours, and was in all respects the most normal labor I ever witnessed. After delivery albumin steadily diminished. The patient did well until the seventh day, when she had a chill followed by fever which lasted ten days and ranged from 102° to 105.3° , with rapid pulse and sweats. During this time the urine contained only a trace of albumin.

I was unable to explain the cause of the fever until I discovered that the nurse was visiting and nursing a case of childbed fever with "erysipelas of breast."

On the third day of normal temperature albuminuria again set in with intense headache, neuralgia, and vomiting. General anasarca followed, with some pleuritic effusion and edema of both lungs, followed by cyanosis and dyspnea. Eventual restoration of health. Six months later urine normal, and frequent examinations since have indicated no return of the trouble. Child had clubfoot (talipes varus). Applied splint and starch bandage for three weeks, resulting in a cure. Patient has been entirely well since until the fifth confinement, July 10th, 1889, when she presented the condition which is the basis of this paper.

Last menstruation appeared September 23d, 1888. Pregnancy normal, with no return of albuminuria or other bad symptoms, until July 10th, 1889. She was up and about the house, in perfect health and spirits, and after sitting upon a settee in her chamber for an hour or so, engaged in fancy work, became tired of her position and attempted to lie down.

In doing so she suddenly turned herself around, at the same time elevating both limbs together so as to stretch out at full length. At the instant of doing so she was seized with a severe, sharp pain low down in her left side—or, as she described it, “in her womb”—followed with faintness and nausea, and shortly noticed that she was wet under her clothing, and concluded that the waters had broken. She was soon undeceived, discovering the flow to be blood, which was increasing steadily in amount, causing greater faintness and weakness.

This occurred about 2:30 P.M., and I arrived about 3:30.

She was then lying upon the bed, where she had been lifted, was very pale and blanched, with sighing respiration, could scarcely speak above a whisper. Her pulse, while distinctly felt at the wrist, was too rapid to be counted. The blood had flowed in such quantity as to pass entirely through the sofa to the floor, and there was a stream leading across the room to the bed. Her clothes were saturated, and clots had formed about the thighs and buttocks, while a small, steady stream poured from the vagina.

After removing the clothes, clots, and fluid blood, examination per vaginam showed the os to be dilated about the size of a silver dollar, membranes very thick, while a flow of hot blood could be felt pouring out from the os.

The uterus appeared to be inert and flabby, and upon introducing the finger into the os and sweeping it around in all directions, no part of the placenta could be felt. Pains were entirely absent, and she was growing steadily and rapidly weaker.

The uterus was normal in size and consistence, but on the anterior left aspect there was a decided irregularity or bulging. Auscultation at this point revealed absence of sound, but around it the placental or uterine bruit was well marked. The diagnosis of partial separation of placenta was made at once. I was alone, out of telephonic communication, without any instruments, and with the patient dying from hemorrhage.

I concluded that the only hope lay in the tampon checking the hemorrhage. I endeavored to introduce one, but failed, and the attempt was so painful, the patient using what little

strength she had left to complain, that I discontinued my efforts and went in search of assistance and instruments. Upon returning I found the bleeding had subsided considerably, but the patient was much weaker. I removed all clots from vagina, and, introducing speculum, proceeded to tampon. I had discovered that the membranes were very tough and non-adherent at lower uterine segment; so, in the absence of a Barnes' bag, I carefully introduced the strip of cotton, previously saturated with carbolized vaseline, into the cervix through the os.

These manipulations at first caused the bleeding to increase, but I continued the work with all possible speed until I had gotten all that was possible into the uterus. I continued the operation until the vagina was distended to its utmost, and completed it by applying a firm bandage over the vulva and abdomen, including a compress over the uterus. All bleeding now ceased, and the patient, much to my relief, began to gain strength and show improvement in the pulse.

I examined and found the fetal heart beating, but never expected it to pulsate outside of that uterus. In the course of half an hour pains began to set in and became quite strong. A very noticeable feature at this stage of the case was that every pain, contrary to my expectations, seemed to add to the patient's strength.

I then left to procure my instruments, etc., and on my return found the patient much stronger and having strong and regular bearing-down pains. Examination showed the bandage and tampon entirely dry. Shortly the tampon commenced to be pressed out of the vagina, so I removed the bandage and proceeded to draw on the end of the continuous cotton strip forming the tampon. As I did so the head followed rapidly downward and the child was born at 5:30 P.M.

The funis was long and not around the neck, and the child, though apparently dead, was easily resuscitated. The liquor amnii was not mixed with blood; a large amount of clotted blood came away with the secundines, which were removed by Credé's method.

The opening in the membranes through which the child passed was almost opposite the placenta.

The placenta showed clearly the portion separated, which

was about one-fourth its surface and at a point farthest from the insertion of the funis. It was a battledoor.

The mother improved steadily without a bad symptom, and is in perfect health to-day.

The child had a clubfoot (left talipes varus), which was treated with splint and starch bandage, and resulted in a cure.

The differential diagnosis in this case had to be made between placenta previa, rupture of lower portion of cervix or corpus uteri, and partial separation of placenta. I will not take up the time of the Society to go further into this subject, as the diagnosis presented no difficulties whatever.

